THE MEDICAL STAFF AND THE HOSPITAL*

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I AM pleased to have the opportunity of discussing the role of surgery in the structure of the hospital as a community facility. A key issue that has been brought to the attention of the public in the recent past concerns the patient-surgeon relation. What is the responsibility of the attending or private surgeon in performing part or all of the operative procedure? I shall discuss this issue in more detail as it concerns all of us responsible for postgraduate medical education. In this context several aspects need to be empahsized. 1) There is a demand and a need for our discipline to maintain training standards to insure future generations of quality-trained surgeons. 2) There are inadequacies in the postgraduate educational system which, in the recent past, have proved more troublesome for the discipline of surgery than for other fields of medicine. 3) And what is the patient's role in postgraduate surgical education?

Before one becomes too critical or condemns the existing residency system, a brief note should be emphasized. Prior to the development of the Halsted system of residency training initiated in the late 1890s the surgeon, as in other trades, learned by way of an apprenticeship with a senior surgeon. It was possible that an apprentice might never perform an operation, and there were no mechanisms for evaluation of an individual's performance. The development of a residency system for postgraduate training in surgery in which progressive graduated levels of responsibility were defined revolutionized surgical postgraduate education. This system has been extremely successful and has produced surgeons of the highest quality. So, before one too quickly discards our present system, he must recognize that the end product of this system,

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in general, has been good and that the patient-consumer has benefitted.

In recent years surgical residency training programs have fallen into difficulties primarily because they were dependent on the socioeconomic status of patients. As more people became insured, the number of patients not covered by any type of health insurance, medicaid or medicare, etc., decreased and, as a result, changes in the residency training system have become imperative.

One must recognize that surgery is different from other disciplines of medicine in that the patient is primarily concerned with the question of who actually performs the operation. The patient or consumer does not question as severely as he should the value of judgment, pre- and postoperative care, or decisions regarding the type of operative procedure. Unfortunately, we have been concerned primarily with who did the actual, technical portion of the operation. Without question, the technical portion of the operation is of extreme importance but it comprises only a part of the education of a surgeon. Judgment which comes from experience concerning the total care of the patient is of paramount significance. Thus when the resident surgeon performs the operative portion of the therapy in the presence of an attending or private surgeon it does not necessarily imply that the patient was treated by a surgeon other than the physician with whom the patient contracted. Actually, in all fields of medicine, the patient's doctor does not attend all of the needs of his patient. The attending surgeon directs, assists and, most important, his judgment prevails during the entire hospitalization. This judgment is exercised in all decisions made in the operating room, including whether a resident is capable of performing the technical part of the therapy. A training system based on the concept that all patients admitted to a service or ward must be operated on by a resident physician is ill-founded. Such an approach certainly does not guarantee that each patient will benefit from the best available knowledge or judgment. Yet the training of qualified surgeons of the future must be guaranteed, and a system which allows education to continue while providing the highest quality care must be supported.

A major problem in surgery rests in our inability to define goals in individual hospitals. At present we cannot define or separate service and education in residency systems. A certain hospital may require a large service component from its house staff. In order to provide this service the size of the house staff is large, yet the training commitment of the

attending staff may be minimal. An immediate answer would be to upgrade the teaching commitment or, as commonly referred, let the resident do more cases. A more critical question is: Do we need the additional number of surgeons that this answer would imply?

Uniformly, the resident training program has become a status symbol. The staff of a hospital without one, assuming the hospital is of proper size to support such a program, may feel deprived. The staff will state that the residents stimulate and upgrade care. In general, I believe this to be true. Nevertheless, a hospital requiring personnel primarily for the provision of service should consider training physicians or associate physicians to provide the necessary service without a vertical education program as an enticement. This is of extreme importance, since I do not feel that an inadequate residency training should be the method of providing service. By use of the present method we shall only increase the number of specialists with little concern for quality control. This matter should be a major concern of those interested in postgraduate education. At present service is provided under the guise of education. Hospitals must recognize a need to employ a staff concerned only with service. Education within these lines would be related to further improvement in the delivery of service. Fortunately, in some ways, the problem is being recognized. For example, operation of the emergency room or clinic by full or part-time staffs concerned only with delivery of care is encouraging. Disciplines such as radiology, pathology, and anesthesiology, although in some areas controversial, have become recognized service needs of the hospital. Yet these disciplines continue educational residency programs without dependence on service requirements as guidelines for size and number of staff.

The most difficult question facing us is the role of the patient in postgraduate education. I believe that a properly constructed residency program which has a number of trainees adequate to the abilities of the staff and hospital to provide the proper educational environment is mandatory. This means that in a hospital one patient could be on a service which is involved with the postgraduate program while another patient may be on a floor without house staff but manned by service-obligated personnel and the patient's physician. The public should recognize that the general welfare of each patient has always been the major concern of each physician. The patient should be guaranteed that he will receive the best care in the judgment of the attending

surgeon. Who actually does the major portion—the technical part of the operation—probably is not as important as the over-all judgment exercised in the total care. Each patient deserves the best available diagnosis and therapy. Yet the training of high-quality, competent, innovative surgeons must continue or we shall be jeopardizing the quality care of future generations. Thus a rational balance must be achieved. The hospital environment must excel in quality of care and service yet have significant commitment to regulate the educational program to the number of quality-trained personnel it can produce. Flexibility in systems must be developed so that personnel related to training residents and service might be structured properly into hospital and departmental functions. We must face the reality that new methods of delivering quality care must be developed which will include numbers of postgraduate surgical trainees sufficient only to meet the needs of the nation and for whom quality education can be provided by the individual hospital. Thus the feeling that every patient admitted to a teaching hospital is the responsibility and under the total jurisdiction of a resident must be dismissed. The physician or surgeon complaining about such a policy should not be required to submit his patient to any involvement in resident training. Thus the responsibility of the department of surgery and the hospital is to regulate the size of resident staffs so as to guarantee adequate training and at the same time employ alternate methods of delivering service.